OCC Inquest Geddes 2018

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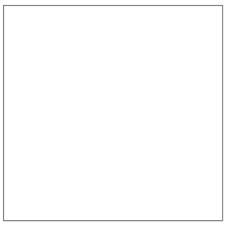

Verdict of Coroner's Jury

Office of the Chief Coroner

The Coroners Act - Province of Ontario

Name(s) of the deceased: GEDDES, Cleve Gordon

Held at: Ottawa, ON
From the: 26-29th of November, 2018
To the: 10-14, 17th of December, 2018
By: Dr. Michael B. Wilson, Coroner for Ontario
having been duly sworn/affiremed, have inquired into and determined the following:

Surname: Geddes
Given name(s): Cleve Gordon
Age: 30
Date and time of death: February 10, 2017 at 3:13 p.m.
Place of death: The Ottawa Hospital, 501 Smyth Rd., Ottawa, ON
Cause of death: Hypoxic-ischemic encephalopathy
By what means: Undetermined

(original signed by Foreman and Jurors)

This verdict was received on the 17th of December, 2018
Coroner's Name: Dr. Michael B. Wilson
(original signed by coroner)

We, the jury, wish to make the following recommendations:

Inquest into the death of:

Cleve Gordon Geddes

Jury Recommendations

To: the Ontario Provincial Police (OPP) and the Ministry of Community Safety and Correctional Services (MCSCS):

1. The OPP and MCSCS should ensure that all front line uniform members are trained and aware that incarceration is often harmful for persons suffering from mental illness, custody may make their condition worse, and they have an increased suicide risk in detention. The following should be considerations when dealing with persons with mental illness: Pre-charge Diversion and engagement with local community mental health services, such as the Assertive Community Treatment Teams and Mobile Crisis Teams.
2. The OPP and MCSCS should ensure that every OPP uniform member has regular training on the guide "Not Just Another Call…..Police Response To Persons with Mental Illnesses in Ontario" including de-escalation techniques and options under the *Mental Health Act*.
3. The MCSCS should review section 3(e) of the Provincial Police Standards Manual to determine whether this wording needs to be amended to provide better guidance and/or direction regarding "compelling circumstances" and to ensure it is consistent with the Mental Health Act, and that it takes into account the circumstances of the offence and the individual, and provides better guidance to officers regarding appropriate circumstances to consider hospitalization or other options.
4. The OPP and MCSCS should consider whether each OPP Detachment should have a dedicated

Mental Health Community Liaison Officer who is tasked with strengthening appropriate, collaborative police/community partnerships with mental health response models such as Assertive Community Treatment and Mobile Crisis Teams and providing advice and training to uniform members who may be interacting with individuals with mental illness.

5. All active uniform members at the Killaloe OPP Detachment should make best efforts to attend any regular training offered by Renfrew Community Health Services staff to learn about the Assertive Community Treatment (ACT), Mobile Crisis Teams, or any other available resources, and how they can support police responding to calls involving individuals with mental illness.
6. The OPP consider reviewing its Police Orders (policies) to ensure that the InterRAI Brief Mental Health Screening form is provided to correctional institutions and/or hospitals when appropriate.
7. The OPP and MCSCS should ensure that all OPP uniform members are trained to recognize that, to address public safety concerns in appropriate circumstances, the provisions of the *Mental Health Act* provides alternatives to arrest under the *Criminal Code* for the apprehension of persons with mental health issues.
8. When dealing with a person believed to have major and/or acute mental health issues, the OPP and MCSCS should make best efforts, where legally permissible, to ensure that the family/support contact is advised that the person is being held in custody or taken to hospital.
9. The OPP and MCSCS should make best efforts to develop a pre-charge diversion protocol on which all uniform members are trained.
10. The OPP and MCSCS should make best efforts to facilitate training of uniform members to work with mobile mental health crisis teams in order to assist them in their interactions with mentally ill individuals whenever possible.

To: Ottawa Carleton Detention Center (OCDC) and the Ministry of Community Safety and Correctional Services

11. The MCSCS and the OCDC, should create a Mental Health Unit at OCDC as soon as possible. This new unit should have specialized staff who have both an interest in and are trained to deal with inmates with mental health issues.
12. In accordance with the Ministry's Suicide Prevention Policy, the MCSCS and the OCDC, should make best efforts to avoid putting inmates who are put on suicide watch in segregation. Subject to documented reasons why there is a safety concern, such inmates should be provided with social interaction as well as appropriate health care and access to programming.
13. A designated member of the nursing team at OCDC should notify the Royal Ottawa Health Care Group (ROH) if an inmate on the Forensic Bed Registry waiting list is identified as suicidal or has a significant deterioration in mental health and document that the notification was made to the ROH.
14. The OCDC should assign a mental health nurse to monitor the status of all inmates who are waiting for an assessment at the ROH including contacting the ROH as needed for updates on the bed list, and bringing forward any pertinent information to the Interdisciplinary Team for advice and further action.
15. The OCDC should ensure that dedicated rooms are available that are proximate to the range or unit where the inmate is housed to avoid the need for assessments to be done through a hatch in the cell door.
16. The MCSCS and the OCDC should make best efforts, upon admission into the institution, to ask inmates if they have an emergency contact/support person. If the inmate consents, the institution should make every effort to make contact with their support person to notify them of the inmate's status and location, particularly where the inmate is identified as having a major mental illness.
17. When an inmate has attempted suicide and is transported to hospital, the OCDC should notify the emergency contact/support person as soon as possible.
18. The MCSCS should ensure that the phone system in correctional institutions is changed to make it easier for inmates to make outgoing phone calls. Specifically, the phones available to inmates should be able to call cell phones and should not make only collect calls.
19. The OCDC should make best efforts that the clinical team's placement recommendations for inmates with mental health issues should be followed whenever possible. When placement recommendations

cannot be followed, the rationale should be documented and the clinical team should be consulted forthwith or as soon as practicable to determine safe alternatives.

20. The MCSCS should revise its Suicide Prevention Policy to ensure correctional officers are advised at the beginning of each shift of any inmate in their area who has recently come off suicide watch or enhanced supervision. For the OCDC this can be during unit "muster" at the beginning of each shift, or through some other reasonable means.
21. The OCDC, should consider whether correctional officers conducting cell checks should carry an emergency response knife to cut down inmates who have hanged themselves.
22. The OCDC may consider that, to ensure the 911 knife is kept in peak condition, the knife should have an easy-to-remove one-time wrapping, such as a taped safety seal.
23. The OCDC should ensure that every correctional officer working in an area with inmates is required to carry a radio to shorten the response time to emergencies.
24. The OCDC should consider the installation of emergency buttons in common areas to shorten response time.
25. The OCDC should consider a mechanism to ensure that the view of the hallway between the dorms can be restricted, by use of one way glass or other suitable methods.
26. The MCSCS and the OCDC should make regular training of correctional officers for suicide response mandatory, scheduled and tracked. The facts of this inquest and other jail suicides as scenarios should be considered in the training, including actual practice in cutting of ligatures.
27. The OCDC should routinely verify that the temperature within the stabilization unit is within acceptable norms; consideration should be given to time of year, inmate activity levels, inmate state of dress, and bedding. Extra blankets should be offered. Consideration should be given to installing data tracking thermometers in appropriate locations and take appropriate measures as required.
28. The MCSCS and OCDC should collaborate to establish a policy that authorizes clinical staff at OCDC, where appropriate, to seek inmate consent to reach out, proactively, to family members and/or support contacts of suicidal or mentally ill inmates so that they may provide support to the inmate.
29. The OCDC should ensure that existing standing orders are followed, or amend standing orders if necessary, so that Admissions and Discharge assist all individuals to complete an initial visitor's list at the time of their admission.
30. The OCDC should amend its standing orders to ensure that if a phone message is left for an inmate, the message is delivered.
31. The MCSCS and OCDC should review the policy forbidding books (except for the Bible and the Koran) for inmates under suicide watch or enhanced supervision. Inmates should be allowed to have other reading materials that do not pose a safety concern.
32. OCDC Admissions and Discharge should, as a matter of standard procedure, send a copy of the court order for a ROH assessment to the jail clinical/medical staff.

To: the Ministry of Community Safety and Correctional Services

33. The MCSCS should review salary and benefits in order to attract and hire more psychologists for the OCDC to increase staffing including the possibility of contracting with external sources in order to make best efforts that there is a mental health professional on duty in the evenings and the weekends.
34. The MCSCS should give consideration to whether all clinical staff at correctional institutions should have electronic access to an inmate's medical and psychiatric history. Correctional institution records, such as watch initiation notices and care and recovery plans, should be in electronic form and easily available to clinical staff.
35. The MCSCS should review suicide prevention and suicide rescue training practices at the OCDC and take appropriate measures to ensure all correctional officers are properly trained.
36. The MCSCS should incorporate the World Health Organization publication "Preventing Suicide in Prison" as part of their suicide prevention training.

To: the Ministry of Community Safety and Correctional Services and the Ontario Police College

37. The guide "Not Just Another Call…..Police Response To Persons with Mental Illnesses in Ontario" should be reviewed and consideration should be given to updating it.

To: Royal Ottawa Health Care Group (ROHCG) and The Ministry of Health and Long Term Care (MOHLTC)

38. The ROHCG may consider the potential suicidality of an inmate awaiting a court ordered assessment, along with all other factors taken into consideration in determining prioritization of individuals on the bed waiting list.
39. The Forensic Bed Waiting List should include functionality to show how many people are on the waiting list for each facility in order to assist the court in making the referral.

To: the Royal Ottawa Health Care Group, Ministry of Health and Long Term Care, Ottawa Carleton Detention Center, Ministry of Community Safety and Correctional Services

40. This inquest in itself proved useful for all parties to understand the inter- relationships and effects of decisions, processes and policies on the system up and down stream. When an apparent suicide occurs in custody, the MCSCS/OPP, MOHLTC, ROHCG and OCDC should consider holding an independently facilitated end-to-end mentally-ill inmate-centric process review with representation from stakeholders and technology/data. Such a facilitated review is intended to be completed in a condensed period of weeks.
41. In collaboration, the MCSCS, the MOHLTC, the ROHCG and the OCDC should continue to engage in discussion with respect to the implementation of an adapted Forensic Early Intervention Service (FEIS) model between the ROHCG and the OCDC.
42. The MCSCS should continue to work on police/hospital transfer of care protocols with the aim of ensuring officers are able to return to regular duty in a timely manner.

To: the Ministry of Health and Long Term Care, and the Pembroke Regional Hospital

43. Court Mental Health Workers should be trained about the different options available in court to deal with persons with mental health issues, including the possibility of post-charge diversion and admission to hospital under Sections 21 and 22 of the *Mental Health Act*.

To: the Chief Justice of the Ontario Court of Justice

44. The Chief Justice of the Ontario Court of Justice should ensure that all Judges of the court are trained and knowledgeable about the following in relation to mentally ill accused person who appear before them:
    a. The conditions of confinement for mentally ill accused persons which exist in detention centers in their jurisdictions.
    b. The potential negative impacts of detention on mentally ill accused persons, including the increased risk of suicide.
    c. The legal requirements for making orders, pursuant to the *Criminal Code*, for the assessment of criminal responsibility, particularly the presumption against custody.
    d. The need to ensure that a proper determination is made, by use of the Forensic Bed Registry, or otherwise, about the availability of beds at Schedule 1 hospitals before an in-custody assessment order for criminal responsibility is made.
    e. The need to ensure that an accused person who is subject to an in-custody assessment order, in circumstances where a bed is not immediately available, is informed that they may be required to be confined in a detention centre for some time before a bed becomes available in a Schedule 1 hospital.
    f. The availability and appropriate use of Brief Assessment Units (BAU) where they exist in

Schedule 1 hospitals.

g. The circumstances where an order under Section 21 and 22 of the *Mental Health Act* may be appropriate for dealing with a mentally ill accused.
h. The use of post-charge diversion programs to deal with mentally ill accused persons when appropriate.
i. In every case where an in-custody assessment under the Criminal Code is considered, Judges and Assistant Crown Attorneys should be aware of whether a bed in a forensic unit is available. Where the individual is placed on a waiting list, there should be consideration of having the individual return to Court within seven days if the individual is incarcerated and still on the waiting list.

To: the Attorney General of Ontario

45. The Attorney General should ensure that all Crown Attorneys, Assistant Crown Attorneys, and court Mental Health Support workers are trained and knowledgeable about the following in relation to mentally ill accused persons :
    a. The conditions of confinement for mentally ill accused persons which exist in detention centers in their jurisdictions.
    b. The potential negative impacts of detention on mentally ill accused persons, including the increased risk of suicide.
    c. The legal requirements for making orders, pursuant to the Criminal Code, for the assessment of criminal responsibility, particularly the presumption against custody.
    d. The need to ensure that a proper determination is made, by use of the Forensic Bed Registry, or otherwise, about the availability of beds at Schedule 1 hospitals before an in-custody assessment order for criminal responsibility is made.
    e. The need to ensure that an accused person who is subject to an in-custody assessment order, in circumstances where a bed is not immediately available, is informed that they may be required to be confined in a detention centre for some time before a bed becomes available in a Schedule 1 hospital.
    f. The availability and appropriate use of Brief Assessment Units (BAU) where they exist in Schedule 1 hospitals.
    g. The circumstances where an order under Section 21 and 22 of the *Mental Health Act* may be appropriate for dealing with a mentally ill accused.
    h. The use of post-charge diversion programs to deal with mentally ill accused persons when appropriate.
    i. In every case where an in-custody assessment under the *Criminal Code* is considered, Judges and Assistant Crown Attorneys should be aware of whether a bed in a forensic unit is available. Where the individual is placed on a waiting list, there should be consideration of having the individual return to Court within seven days if the individual is incarcerated and still on the waiting list.

46. Consideration should be given to the establishment of a Mental Health Court in Renfrew County based on a model that takes into account local circumstances and is appropriate for that jurisdiction.

To: The Government of Ontario

47. Persons who are apparently mentally ill and have been ordered by the Court to be assessed in a hospital should not be warehoused in detention centers. The Government of Ontario should increase the number of hospital beds available for persons who have been ordered by the courts to have a mental assessment.
48. As soon as feasible, the Government of Ontario should proclaim into force the *Correctional Services and Reintegration Act, 2018*, SO 2018, c 6, Sch 2 (Bill 6), which prohibits placement on segregation of inmates who are suicidal or who have mental illness.

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